WELCOME TO OUR OFFICE

DATE:_____

CHILD'S NAME_____ NICKNAME_____ SEX_____

BIRTHDATE_____ AGE_____ FATHER/PARENT OR LEGAL GUARDIAN_____

MOTHER/PARENT OR LEGAL GUARDIAN_____

BILLING ADDRESS IF DIFFERENT THAN CHILD 'S_____ CITY_____ STATE_____ ZIP_____

PRIMARY DENTAL INSUR. CO._____ SUBSCRIBER_____

SUBSCRIBER'S EMPLOYER_____ SUBSCRIBER'S BIRTHDATE_____

SUBSCRIBER'S ID# (Do NOT e-mail if SSN) _____ POLICY/GROUP # _____

SECONDARY DENTAL INSUR. CO._____ SUBSCRIBER_____

SUBSCRIBER'S EMPLOYER_____ SUBSCRIBER'S BIRTHDATE_____

SUBSCRIBER'S ID# (Do NOT e-mail if SSN)_____ POLICY/GROUP # _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

MEDICAL HISTORY

	YES	NO	FOR DOCTOR'S USE
Former Dentist_____			
City_____ State_____			
Please list any dental concerns_____			
Date of last dental visit_____ Last x-rays_____			
Has your child sustained any injuries to the mouth, teeth, or head?	☐	☐	
If yes, please describe:_____			
Has your child ever been exposed to nitrous oxide (laughing gas)?	☐	☐	
How often are your child's teeth brushed?_____			
How often are your child's teeth flossed?_____			
Is your child regularly exposed to fluoride ___ (listed below)?			
water?	☐	☐	
tablets?	☐	☐	
toothpaste?	☐	☐	
at dental office visits?	☐	☐	
Do you have any specific questions regarding your child's dental care?	☐	☐	
_____			
_____			
_____			
Has your child been treated by a physician in the last five years?	☐	☐	
For what reason?_____			
Has your child gained/ lost more than 10 pounds in the last three months?	☐	☐	
Do they take any medications/herbs (prescribed or over-the-counter)?	☐	☐	
Drug Dose Purpose			
_____			
_____			
_____			
_____			
_____			

	YES	NO	FOR DOCTOR'S USE
Are they allergic to any medications or substances (such as latex, metals, iodine, etc.)? Please list:	☐	☐	

_____

_____

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Please list hospitalizations and/or surgeries:

Date: Procedure:

_____

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	HAS YOUR CHILD EVER EXPERIENCED ANY OF THE FOLLOWING: Congenital	YES	NO	FOR DOCTOR'S USE
1	birth defects, heart or otherwise	☐	☐	
2	Rheumatic fever	☐	☐	
3	Heart murmur	☐	☐	
4	High blood pressure	☐	☐	
5	Asthma	☐	☐	
6	Tuberculosis	☐	☐	
7	Liver disease–hepatitis, jaundice	☐	☐	
8	Kidney disease	☐	☐	
9	Seizures, convulsions, epilepsy	☐	☐	
10	Loss of consciousness	☐	☐	
11	Excessive bleeding when injured	☐	☐	
12	Thyroid gland disease	☐	☐	
13	Diabetes	☐	☐	
14	Malignancy, cancer	☐	☐	
15	Chemotherapy or Radiation Therapy	☐	☐	
16	Artificial joint, valve or prosthesis surgically implanted	☐	☐	
17	HIV, AIDS, or exposure to the AIDS Virus	☐	☐	

Signed_____

Date_____

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Updated_____

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Summary_____

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